STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING 00 B. WING	05/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00108375 and IN00108956. Complaint IN00108375-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F314, F315, F323, F441, and F514. Complaint IN00108956-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F315, F323, and F441. Survey dates: May 29 & 30, 2012 Facility number: 012329 Provider number: 155784 AIM number: 201002500 Survey team: Janet Adams, RN Census bed type: SNF: 28 SNF/NF: 44 Total: 72 Census payor type; Medicare: 27 Medicaid: 25 Other: 20	F0000	This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constiute admissionor agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correctionis prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Total: 72 Sample: 8 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 5, 2012 by Bev Faulkner, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, record review, and interview, the facility failed to notify the resident's family or physician of a fall, drainage at a suprapubic urinary catheter site, and a suprapubic catheter not	F0157	It is the practice of this facility that the resident, resident's physician and resident's family or legal representative will be informed when there is an accident involving the resident which	06/21/2012

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	functioning properly for 2 of 8 residents reviewed for change in condition in the sample of 8. (Residents #D and #E) Findings include: 1. On 5/29/12 at 10:10 a.m., Resident #E was observed in bed. The resident had a suprapubic catheter(an urinary catheter inserted into the bladder through the abdominal area in place) in place to the abdominal area. The resident had a hospital gown on. There was a round area of dried dark, reddish/brown drainage on the resident's hospital gown. LPN #1 lifted the resident's gown and there was dried brown/red colored drainage on the dressing approximately 1.5 cm (centimeters) in diameter where it was covering the insertion site. LPN #1 removed the dressing and cleansed the insertion site with wound cleanser and placed a dry dressing over the site. On 5/30/12 at 7:35 a.m., the resident was observed in bed. Unit Manager #1 assessed the dressing to the suprapubic site. There was a circular area of light red/brown drainage on the dressing approximately the size of a nickel. The record for Resident #E was reviewed on 5/29/12 at 11:00 a.m. The resident's		results in injury and has the potential for requiring physician intervention; a significant change in the residents physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility. **Corrective Action:** Residents who have a suprapubic catheter have been seen by the physician. Families have been informed of the suprapubic catheter drainage and the site of insertion. All nurses will be re-educated about checking the boxes on the physicians phone orders that indicate family was notified and to document in the nurses notes that family and physician were notified. The night nurse on each unit will be responsible for The double check that physician and family were notified. They will look at the green copy of the physician phone order to ensure that the nurse who wrote the order check the box indicating the physician and family were notified. Then check the nurses note to ensure it was documented. The night nurse will then initial the green copy that indicates the checks were completed. **How Others Identified:** All residents will have the above process completed with each physicians order. Residents residing in the facility will be addressed by following policy and procedure and re-educated	

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	diagnoses included, but were not limited to, benign prostatic hypertrophy, depression, peripheral vascular disease, and diabetes mellitus. The resident was sent to the hospital on 5/14/12 for insertion of the suprapubic catheter on 5/14/2012. A physician's order was written on 5/14/12 to change the dressing to the suprapubic catheter site daily and as needed. The dressing change treatment was signed out as completed 5/15/12 through 5/29/12. Review of the 5/2012 Nurses Progress Notes indicated an entry was made on 5/19/12 at 12:30 a.m. This entry indicated the resident was receiving Cipro (an antibiotic) related to the suprapubic insertion surgery. An entry made on 5/19/12 at 4:00 a.m., indicated a skin assessment was completed and large amounts of drainage was observed at the suprapubic site and the open area was very red and had a strong odor. The Physician was called and stated he wanted to be called again at 8:00 a.m., to see what urologists were available. The next entry was made on 5/19/12 at 1:00 p.m. This entry indicated the resident's suprapubic catheter was not draining and staff attempted to flush the catheter multiple times. The resident's abdomen was red and tender to touch with drainage noted from the insertion site. The		and/or disciplinary action of employees. **Preventative Measures:** The Unit Managers (UM), Assistant Director of Nursing (ADON) or designee will check the green phone orders to ensure they have been initialed. The UM, ADON, or designee will also check the nurses notes, MAR's, TAR's to ensure documentation was completed. **Monitoring:** The ADON, Director of Nursing (DON), or designee will check the green orders each morning during clinical review, to ensure they have been initialed. The monitoring log will be checked daily for 2 weeks, 3 times a week for 2 weeks, weekly for 4 weeks, then monthly for 3 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. **Systems Changes:** Competed by 6/21/2012.	

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	Physician was called and orders were given for Keflex (an antibiotic) to be given four times a day. An entry made on 5/23/12 at 8:00 a.m., indicated the dressing to the suprapubic site was changed and a large amount of purulent drainage was present on the old dressing with a small amount if bloody drainage mixed in. There were no further entries made after this. When interviewed on 5/30/12 at 11;15 a.m., the ADON (Assistant Director of Nursing) indicated the resident was treated with Keflex for 7 days starting on 5/19/12. The ADON indicated the resident's Physician should have been notified of the resident having continued drainage. The ADON indicated the resident's Physician should have been called back at 8:00 a.m., on 5/19/12 as he had instructed. 2. The closed record for Resident #D was reviewed on 5/29/12 at 2:30 p.m. The resident's diagnoses included, but were not limited to, renal failure, history of a fall, weakness, and fracture of the neck of the femur(a bone in the leg). The resident was admitted to the facility on 4/20/12. Review of the 5/2012 Nursing Progress Notes indicated an entry was made on 5/7/12 at 6:45 p.m. This entry indicated			

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	the resident was calling down the hall for the nurse. The resident was found sitting on the floor by his bed and stated he slipped out of his chair. Neuro checks(assessment to determine if any changes were noted in the neurological status) were initiated. The entry also indicated the resident was to be non weight bearing to his right hip. A Communication and Progress Note, dated 5/7/12, indicated the Physician was notified of the resident's fall. There was no documentation in the Nursing Progress Notes or the Communication and Progress Note to indicate the resident's family was notified of the fall. When interviewed on 5/30/12 at 12:45 p.m., the ADON indicated the resident's family should have been notified of the fall. This federal tag relates to Complaints IN00108375 and IN00108956. 3.1-5(a)(2)			

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to provide treatment and services to promote wound healing related to Prevalon boots (soft boots to relieve pressure) were in place as ordered for 3 of 3 residents with orders for Prevalon boots in sample of 8. The facility also failed to ensure the correct wound care treatment was rendered for 1 of 3 residents reviewed for wounds in the sample of 8. (Residents #B, #E, and #G) Findings include: 1. On 5/29/12 at 2:30 p.m., Resident #G was observed in bed. The resident had gauze dressing in place to the right ankle area and a foam dressing in place to left heel area. The resident did not have any Prevalon boots on. On 5/29/12 at 4:00 p.m., the resident was	F0314	**F 314** It is the practice of this facility that each resident who enters the facility without a pressure sore does not develop one unless the individual's clinical condition demonstrates that they were unavoidable; and a resident who has pressure sores receives necessary treatment and services to promote healing.**Corrective Action:** Residents who have orders for prevalon boots have been assessed to ensure they have the boots available, the boot are care planned, the CNA sheet indicates the resident is to wear them and the times they are to be on and off. Resident G was reassessed and care plans reviewed ensuring treatment is correct and reflective of current status. **How Others Identified:** Reisdents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees. 100% audit for residents with physician orders for prevalon boots	06/21/2012

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	observed in bed. The resident's heels were resting on the mattress. The resident did not have any Prevalon boots on. On 5/30/12 at 9:20 a.m., the resident was observed in bed. The resident had a pink foam dressing in place to his left heel. The resident was not wearing any Prevalon boots at this time. The record for Resident #G was reviewed on 5/29/12 at 12:30 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, diabetes mellitus, and cerebral vascular accident (stroke). Review of the 5/2012 Physician Order Statement indicated there were Physician orders for the resident to have Prevalon boots on while in bed for pressure ulcers. There was also an order to cleanse the left heel with Dakin's solution, apply calcium alginate and cover with Allevyn heel dressing daily and as needed. The Skin Grid reports for 4/2012 and 5/2012 were reviewed. A Skin Grid report form indicated the resident had a Stage II (a partial thickness wound presenting as a shallow open area with a red pink center) pressure ulcer to the right malleous area. On 5/1/12 the wound measured .3 cm (centimeters) x .2 cm. A		completed. Ensuring care plans and CNA shets are reflective of current status. **Preventative Measures:** The UM, ADON, or designee will monitor the TAR to ensure the nurse is completing the weekly skin assessment. Monitor the CNA assignment sheets to ensure the information about the prevalone boots is available. All nurses and CNA's will be re-educated about proper skin assessments and skin checks. Also, the proper use of prevalone boots.**Monitoring:** The UM, ADON, DON, or designee will monitor the availability and use of the prevalon boots during their rounds. During rounds the UM, ADON, DON and/or designee will use a monitoring log to check three (3) residents daily for 2 weeks, weekly for 4 weeks, then monthly for 3 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA monthly, to determine further educational needs.**Systems Changes:** Completed by 6/21/2012	

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	Skin Grid Report form indicated the resident had a unstageable wound to the left heel. On 5/22/12, the wound measured 1.6 cm x 1.6 cm. A Physician's order was written on 4/28/12 to discontinue all previous treatments to the right ankle. Review of the 5/2012 Treatment Record indicated there was a treatment to cleanse the right ankle with normal saline, pat dry apply Santyl (a topical ointment to deride wounds) to the area and cover with a dressing every 72 hours and as needed. The treatment was signed out as completed on 5/1/12, 5/4/12, 5/7/12, 5/10/12, 5/13/12, 5/16/12, 5/19/12, 5/22/12, 5/15/12, and 5/28/12. When interviewed on 5/30/12 at 11:15 a.m., the ADON indicated the resident should have had the Prevalon boots in place when he was in bed. The ADON also indicated the wound treatment to the right malleous (ankle) had been discontinued. The ADON indicated she interviewed staff nurses and they indicated they had been doing the treatment to the right ankle after the area healed. The ADON indicated the order was written on 4/28/12 to discontinue the right ankle treatment.			

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	2. During orientation tour on 5/29/12 at 9:25 a.m., Resident #E was observed in bed. The resident had a dressing in place on the right ankle area. The resident's heels were not elevated off the bed. The resident did not have a Prevalon boot on either foot. On 5/29/12 at 10:10 a.m., LPN #1 was observed providing wound care to the resident's right heel area. The was a small black scabbed area to the right heel measuring approximately 0.5 cm x 0.5 cm, the surrounding skin was intact. The LPN cleansed the area with wound cleanser and applied a dressing. The LPN completed the treatment and left the resident's room. LPN #1 did not place any boot on the resident's right foot. On 5/29/12 at 2:35 p.m., the resident was observed in bed. The resident did not have a Prevalon boot in place to the right foot. On 5/30/12 at 8:10 a.m., the resident was observed in bed. There resident had a dressing in place to the right ankle area. The resident's right foot was resting on the bed mattress. The resident did not have a Prevalon boot on the right foot. The record for Resident #E was reviewed on 5/29/12 at 11:00 a.m. The resident's			

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	diagnoses included, but were not limited to, congestive heart failure, peripheral vascular disease, diabetes mellitus, and depression. Review of 5/2012 Treatment Record indicated there was an order for the resident to wear a Prevalon boot to the right foot while in bed. There was also a wound care order for a Allevyn heel guard to be applied to the right foot. Review of the 5/2012 Skin Grid ulcer report indicated the resident had a right heel wound. Documentation on 5/22/12 the wound was described as suspected deep tissue injury(purple or maroon localized area of discolored skin or blood filled blister) measuring 4.2 cm x 2.4 cm. When interviewed on 5/30/12 at 11:15 a.m., the ADON indicated the resident should have had the Prevalon boot on the right foot when he was in bed. 3. During orientation tour on 5/29/12 at 9:25 a.m., Resident #B was observed sitting in a wheel chair in his room. The resident had dressings in place to both his right and left feet. On 5/29/12 at 3:55 p.m., Resident #B was observed in bed. The resident had blue socks on both feet. The resident did not have any Prevalon boots on either foot.			

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	The record for Resident #B was reviewed on 5/29/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, anemia, and acute renal failure. Review of the 5/2012 Physician orders indicated there was an order written on 5/17/12 for the resident to wear Prevalon boots while in bed. There was also an order written on 5/17/12 to cleanse the areas to both heels with soap and water, pat dry, and apply Santyl and calcium alginate, then cover with a Allevyn border dressing. The 5/2012 Skin Grid reports indicated the resident had a Stage II pressure ulcer to the left heel. An entry made on 5/22/12 indicated the pressure are measured .4 cm x .4 cm. The report also indicated the resident had a Stage II pressure area to the right heel. An entry made on 5/22/12 indicated the ulcer measured 1.2 cm x 1.8 cm. When interviewed on 5/30/12 at 11:15 a.m., the ADON indicated the resident should have had the Prevalon boots on as when he was in bed. This federal tag relates to Complaint IN00108375.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	1420 E DOUGLAS RD MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interview, the facility failed to ensure treatment was provide to treat a urinary tract infection related to not obtaining culture results to verify the correct antibiotic treatment was provided for a urinary tract infections for 1 of 3 residents reviewed for urinary tract infections and catheters in the sample of 8. The facility also failed to ensure a resident with complications from the use of urinary catheter was assessed thoroughly for 1 of 3 residents reviewed for urinary infections and catheters in the sample of 8. (Resident #E) Finding include: During orientation tour on 5/29/12 at 9:25 a.m., Resident #E was observed in bed. The resident had a suprapubic catheter (a urinary catheter inserted into the bladder	F0315	**F 315** It is the practice of this facility to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and residents who are incontinent of bladder receives appropriate treatment and services to prevent UTI's. **Corrective Action:** 100% audit on all residents who have a Foley catheter and are on an antibiotic for a UTI. This is to ensure the culture and sensitivities are in the chart and the appropriate antibiotic is being given. When a resident is admitted to the facility with a UTI, the nurse is to ensure that a culture and sensitivity are available or obtain it from the hospital if not available. Resident E was reassessed ensuring orders and care plans are reflective of current status. **How Others Identified:** 100% audit on all residents who have a Foley	06/21/2012

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	through the abdominal area) in place. On 5/29/12 at 10:10 a.m., Resident #E was observed in bed. The resident had a suprapubic catheter (an urinary catheter inserted into the bladder through the abdominal area in place) in place to the abdominal area. The resident had a hospital gown on. There was a round area of dried dark reddish/brown drainage on the resident's hospital gown. LPN #1 lifted the resident's gown and there was dried brown/red colored drainage on the dressing approximately 1.5 cm (centimeters) in diameter where it was covering the insertion site. LPN #1 removed the dressing and cleansed the insertion site with wound cleanser and placed a dry dressing over the site. On 5/30/12 at 7:35 a.m., the resident was observed in bed. Unit Manager #1 assessed the dressing to the suprapubic site. There was a circular area of light red/brown drainage on the dressing approximately the size of a nickel. The record for Resident #E was reviewed on 5/29/12 at 11:00 a.m. The resident's diagnoses included, but were not limited to, urinary tract infection, high blood pressure, peripheral vascular disease, and diabetes mellitus. The resident was sent to the hospital on 4/30/12 and returned to		catheter and are on an antibiotic for a UTI were reviewed to ensure appropriate orders and care plans are reflective of current status. **Preventative Measures:** All nurses will be educated to check the culture and sensitivity report to ensure the proper antibiotic is being given. Also, educated that upon each admission, if the resident has a UTI, there is to be a culture and sensitivity report if not, they are to obtain one from the hospital. **Monitoring:** The UM, ADON, DON, or designee will use the monitoring log to ensure all residents who have a Foley catheter and a UTI, have a sensitivity report in their chart. The UM, ADON, DON and/or designee will use a monitoring log to check daily. for 2 weeks, 3 times a week for 2 weeks, weekly for 4 weeks, then monthly for 3 months new antibiotic orders for residents with foley caths. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs.**Systems Changes:** Completed by 6/21/2012	

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	the facility on 5/2/12. Review of the 5/2/12 hospital transfer order form indicated orders were written for the resident to receive Levaquin (an antibiotic) 500 milligrams once a day for 10 days to treat a urinary tract infection. Review of the 5/2/12 hospital Discharge Summary report indicated the resident's urinalysis was positive for an urinary tract infection and the culture results were pending. The summary also indicated the resident was started Levaquin 500 milligrams once daily for ten days. Results of the hospital urinalysis and culture were not available in the resident's record at the time of review. The results of the culture and sensitivity were faxed to the facility on 5/29/12 at 2:26 per request.. The final culture and sensitivity report was completed on 5/4/2012. The results were positive for greater then 100,000 proteus mirabilis (an infection). The sensitivity report indicated proteus mirabilis was resistant to Levofloxacin (Levaquin). The 4/2012 Nursing Progress Notes were reviewed. There was an entry made on 4/9/12 at 10:00 a.m. The entry indicated the resident stated his Foley catheter was not patent. The Foley was flushed to make			

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	sure it was patent. The Foley bag was bright red blood and the physician was notified and staff instructed to recheck in one hour. The next entry in the Nursing Progress Notes was made at 11:30 a.m. This entry indicated the resident's Foley continued to be bloody and the resident complained of burning at the catheter insertion site. The physician was called and staff were waiting for a response from the doctor. The next entry was made at 6:30 p.m. There was no documentation of an assessment of the Foley catheter drainage. The next entry was made on 4/12/12 at 10:55 a.m. There was no assessment of the resident's urine or his complaints of burning. The 5/2012 Nursing Progress Notes were reviewed. There was an entry made on 5/19/12 at 4:00 a.m. This entry indicated the resident's suprapubic catheter was occluded and staff were unable to flush the catheter. Large amounts of drainage was noted at the suprapubic site and the area was red and had a strong odor. The physician was notified and he instructed staff to call him back at 8:00 a.m. to see which urologist were available. The next entry was made on 5/19/12 at 1:00 p.m. This entry indicated the resident's suprapubic catheter was not draining and Keflex (an antibiotic) was to be started and a urethra Foley was inserted. The			

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	entry also indicated the resident's abdomen was red and tender and drainage was noted from the incision. The next entry was made on 5/19/12 at 11:00 p.m., and this entry indicated the resident remained on antibiotics for redness to the abdomen. The next entry in Nursing Progress Notes was made on 5/22/12 at 1:00 a.m. This entry indicated the catheter was draining clear yellow urine. An entry made on 5/23/12 at 8:00 a.m., indicated the dressing to the resident's suprapubic catheter insertion site was changed and a large amount of purulent drainage was noted on the old dressing with a small amount of bloody drainage mixed in. The next entry in the Nursing Progress notes was not made until 5/29/12. Review of the 5/2012 Physician orders indicated an order was written on 5/19/12 to discontinue the Cipro (an antibiotic) and start Keflex 500 milligrams twice day for 7 days. The order for the Cipro was initially written on 5/14/12 after the resident's suprapubic catheter insertion. When interviewed on 5/29/12 at 3:30 p.m., LPN #1 indicated he was caring for the resident on 5/19/12. The LPN indicated the resident had Foley catheter inserted also on 5/19/12. The LPN			

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	indicated the resident had his suprapubic catheter replaced after that. When interviewed on 5/29/12 at 3:40 p.m., the ADON indicated the resident had his suprapubic catheter replaced on 5/21/12. The ADON indicated there was no documentation of this or follow up assessment of this. When interviewed on 5/30/12 at 11:15 a.m., the ADON indicated nursing staff are to document in the Nursing Progress Notes once a shift for 72 hours or until the condition resolves when there is a change in condition. The ADON indicated this should have been done beginning on 4/10/12 when blood was noted in the resident's Foley catheter drainage bag. The ADON also indicated the same follow up charting should have been done after the drainage was noted on 5/23/12. When interviewed on 5/29/12 at 3:30 p.m., the ADON indicated the resident was admitted back to the facility on 5/2/12 with Physician orders to receive Levaquin 500 milligrams. The ADON indicated the facility did not follow through to identify the culture and sensitivity results to properly treat the resident's urinary tract infection.			

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	This federal tag relates to Complaints IN00108375 and IN00108956. 3.1-41(a)(2)			

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F0323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall prevention interventions were in place for resident's identified as fall risks related to alarms not in place which resulted in injury requiring staples for 1 of the 3 who did not have ordered interventions in place for falls. (Residents #H, #B, and #D) Findings include: 1. During orientation tour on 5/29/12 at 8:35 a.m., Resident #H was not observed in her room. CNA#1 was standing in the room by the resident's bed. The bathroom door was almost completely closed. The CNA indicated the resident was in the bathroom. The resident was not in view of the CNA. At this time, Unit Manager #1 indicated Resident #H had frequent falls and recently was sent the hospital Emergency Room for a head injury sustained during a fall. The record for Resident #H was reviewed on 5/30/12 at 10:10 a.m. The resident	F0323	**F 323** It is the practice of this facility to ensure that each resident receives adequate supervision and assistance devices to prevent accidents. **Corrective Action:** 100% audit of all residents with alarms to ensure they are in place, care plannded, and on the CNA assignment sheet. 100% audit of all residents who have had a fall within the last 30 days to ensure care plans are updated and interventions are in place. **How Others Identified:** 100% audit of all residents with alarms. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees whom are found to not follow policy.**Preventative Measures:** Re-educate all nursing staff on residents who are at risk for falling, proper use of bed alarms and proper procedure for resident's who are at risk for falls, and definition of fall and following plan of care for those residents. **Monitoring:** The UM, ADON, DON, or designee will use the monitoring log to ensure all alarms are in place for those	06/21/2012

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	was admitted to the facility on 5/9/12. The resident was admitted from the hospital. The resident's diagnoses included, but were not limited to, Alzheimer's dementia, congestive heart failure, and high blood pressure. Review of the resident's current care plans indicated a care plan was initiated on 5/12/12. The care plan indicated the resident was at risk for falls or injury related to being unsteady, a diagnosis of dementia, receiving diuretics, narcotics, antidepressants and cardiovascular medications. The resident also had exhaustion and weakness. Care plan interventions included for one person assist to be provided for increased supervision and the assist of one staff for ambulation and transfers. Care plan interventions included chair alarm, bed alarm, floor mat and to lock the bed wheels. The care plan indicated the resident had two falls on 5/10/12 and one fall on 5/19/12. An IDT (Interdisciplinary Team) progress note was made on 5/10/12. The note indicated the resident was an "extreme fall risk" and had bed and chair alarms in place. The 5/2012 Nursing Progress Notes were reviewed. An entry made on 5/11/12		residents who have an order. The UM, ADON, DON and/or designee will use a monitoring log to check daily those residents with alarms. Monitoring log to check that those residents who have alarms are care planned and on the CNA assignment sheet.Monitoring log to ensure that any resident with a fall, has a care plan update with an intervention. This will be monitored at the DCR, (daily clinical review) meeting. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA monthly, to determine further educational needs.**Systems Changes:** Completed by 6/21/2012	

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	Communication Progress note indicated the resident fell on 5/10/12 and was sent out the hospital emergency room and received 6 staples to a laceration on the back of her head. The 5/10/12 Resident Transfer Form, completed at 9:00 a.m., indicated the resident fell and sustained a laceration to the posterior scalp area and she complained of pain in her pelvis and had an abrasion to the left elbow. A Resident Incident form, dated 5/10/12, indicated the resident was found laying on the floor next to her dresser. The resident was confused and had attempted to ambulate independently. The resident had a laceration to the back of the head and a skin tear to the left elbow. The resident was sent to the hospital Emergency Room for treatment. The 5/10/12 Emergency Room Discharge Instructions indicated staples were used to repair the scalp wound. When interviewed on 5/30/12 at 12:55 p.m., the ADON indicated the resident was a fall risk and interventions included chair and bed alarms. The ADON indicated the resident had two falls on 5/10/12 and was placed on 15 minute checks. The ADON indicated the resident			

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	required increased supervision and should not have been left alone in the bathroom. The ADON also indicated upon review of the fall of 5/10/12 at 8:57 a.m. The facility identified that the resident's chair alarm was not in place at the time of the fall. She indicated the alarm was observed to be on the dresser in the resident's room. The ADON indicated staff were disciplined for not assuring the alarms were in place. 2. On 5/29/12 at 2:45 p.m., Resident #B was observed sitting in a wheel chair in his room. The resident did not have an alarm in place. There was no alarm device observed in the resident's room. On 5/30/12 at 8:00 a.m., the resident was observed sitting in wheel chair at a table in the lounge area on the unit. The resident did not have an alarm in place The record for Resident #B was reviewed on 5/29/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, pneumonia, diabetes mellitus, and high blood pressure. A care plan initiated on 4/17/12 indicated the resident was at risk for falls or injury related to exhaustion,weakness, and receiving cardiovascular medications. The care plan was last updated on			

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	5/12/12. An intervention for the resident to have a chair alarm was added to the care plan on 5/19/12. The 5/19/12 Nursing Progress Notes were reviewed. An entry made at 8:15 a.m., indicated the resident across the hall from Resident #B notified the nurse the resident was on the floor in front of the wheelchair. The resident denied complaints of pain and was able to move all his extremities. When interviewed on 5/30/12 at 11:15 a.m., the ADON indicated the intervention for a wheel chair alarm to be in place was added to the resident's plan of care on 5/19/12 and the resident should have a wheel chair alarm in place when he is up the wheel chair. 3. The closed record for Resident #D was reviewed on 5/29/12 at 2:30 p.m. The resident was admitted to the facility on 4/20/12. The resident's diagnoses included, but were not limited to, right hip fracture, urinary retention, and skin cancer. Review of the 5/2012 Nursing Progress Notes indicated an entry was made on 5/7/12 at 6:45 p.m. This entry indicated the resident was calling down the hall for			

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	the nurse. The resident was found sitting on the floor by his bed and stated he slipped out of his chair. Neuro checks(assessment to determine if any changes were noted in the neurological status) were initiated. The entry also indicated the resident was to be non weight bearing to his right hip. A care plan initiated on 4/21/12 indicated the resident was at risk for falls or injury related to a right hip fracture, syncope, and a history of a ground level fall. Care plan interventions included for the resident to have the assistance of two staff for ambulation and transfers. No other interventions were checked on the care plan. When interviewed on 5/30/12 at 12:45 p.m., the ADON indicated she was not aware of the resident's fall on 5/7/12. The ADON indicated care plan interventions should have been put into place at that time. The ADON indicated she felt an alarm should have been initiated at this time due to the resident making attempts to transfer and still having orders for non weight bearing due to his recent hip fracture and non weight bearing status. This federal tag relates to Complaints IN00108375 and IN00108956.			

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	3.1-45(a)(2)			

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure	F0441	**F 441** It is the practice of this facility to establish and maintain	06/21/2012

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	155784	A. BUILDING 00 B. WING	05/30/2012

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	hand hygiene was completed after wound care was provided for 1 of 3 residents observed with wounds in the sample of 8. (Resident #E) (LPN #1) Findings include: On 5/29/12 at 10:10 a.m., LPN#1 was observed rendering wound care to Resident #E. The resident was in bed and was wearing a hospital gown. The LPN put a pair of disposable gloves on then removed the gloves and exited the room to get a pair of scissors. The LPN returned to the resident's room and put a new pair of gloves on. The LPN did not wash his hands or use hand sanitizer before putting the second pair of gloves on. The LPN lifted the hospital gown up to expose the abdomen. The resident had a suprapubic (a urinary catheter inserted through the abdominal wall into the bladder. There was a square gauze dressing taped over the catheter insertion site. There was dried, reddish/brown drainage on the area of the hospital gown that was over the insertion site. The area was approximately 2.5 cm (centimeters) in diameter. LPN #1 removed the dressing and cleansed the site with a gauze moistened with wound cleanser. The LPN then removed his gloves and put another pair on and proceeded to cleanse		an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection **Corrective Action:** The nurse was immediately education on handwashing and infection control. Resident "E" was not affected by this practice **How Others Identified:** Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees whom are found to not follow policy. **Preventive Measures:** Re-educate all nursing staff on proper had washing techniques, frequency, and expectation for infection control. **Monitoring:** The UM, ADON, ETD, DON, or designee will monitor one nurse per day for proper technique and frequency of hand washing during a treatment. Both the observer and the nurse will sign the paper that indicates the hand washing procedure was done correctly. One nurse per day for 2 weeks, one nurse 3 times per week, weekly for 4 weeks, then monthly for 3 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will	

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	the area a second time and then applied a split gauze dressing over the catheter insertion site and taped the dressing in place. The LPN then removed his gloves and put a new pair on. The LPN did not wash his hand or use hand sanitizer at this time. LPN #1 then placed a pillow under the resident's right foot and cut off the dressing to the right heel area. There was a foam protector wrapped with gauze on the area. There was a dried intact black scabbed area approximately 0.5 cm (centimeters) x 0.5 cm in to the right heel area. The LPN wiped the wound area with wound cleanser and a gauze. The LPN then removed his gloves and left the room and went to the Nurses station on the unit. The LPN did not wash his hands or use hand sanitizer before exiting the room. LPN #1 opened the door of the Medication Room and obtained a dressing from the treatment cart that was in the room and exited the Medication Room and walked back into the resident's room. The LPN did not wash his hands or use hand sanitizer when entering the resident's room. The LPN put a pair of disposable gloves and proceeded to place the dressing over the resident's heel wound and wrapped the wound. The LPN finished the wound care		result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA monthly, to determine further educational needs. **Systems Changes:** Completed by 6/21/2012	

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	treatments and removed the glove on his right hand in the resident's room and wrote the date on the right ankle dressing. The LPN then took off the glove to his left hand and wrote the date on the suprapubic catheter dressing. LPN #1 then removed the pillow under the resident's right leg. The LPN then moved the trash can in the resident's room and exited the resident's room and walked to the Nurse station. LPN #1 did not wash his hands or apply hand sanitizer before exiting the resident's room at 10:45 a.m. The record for Resident #E was reviewed on 5/29/12 at 11:00 a.m. The resident's diagnoses included, but were not limited to, urinary tract infection, diabetes mellitus, and peripheral vascular disease. Review of the results of the a urine culture obtained on 5/2/12 indicated the urine culture was positive for proteus mirabilis (a bacteria). When interviewed on 5/29/12 at 10:45 a.m., LPN #1 indicated hand washing is to be done before and after treatments. The LPN indicated hand washing should have been done prior to leaving the resident's room. When interviewed on 5/30/12 at 11:15 a.m., the ADON indicated hand washing should have been done after the wound			

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	care treatments when the nurse removed the gloves in the resident's room. This federal tag relates to Complaints IN00108375 and IN00108956. 3.1-18(l)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, record review, and interview, the facility to maintain complete and accurate clinical records related to transcription of physician orders on the Medication and Treatment Records for 2 of 7 residents reviewed for clinical record documentation in the sample of 8. (Residents #E and #G) Findings include: 1. On 5/29/12 at 2:30 p.m., Resident #G was observed in bed. The resident had a gauze dressing in place to the right ankle area and a foam dressing in place to left heel area. The record for Resident #G was reviewed on 5/29/12 at 12:30 p.m. The resident's diagnoses included, but were not limited	F0514	**F 514** It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.**Corrective Action:** 100% audit of all admissions and re-admissions in the past 14 days to ensure all medication have been transcribed accurately. All physicians orders will be double checked by the night nurse. They will look at the green copy of the physician phone order to ensure that the nurse who wrote the order transcribed the order to the MAR/TAR. The night nurse will then initial the green copy that indicates the checks were completed.**How Others Identified:** All residents will have the above process completed with each physicians order.	06/21/2012

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	to, high blood pressure, diabetes mellitus, and cerebral vascular accident (stroke). Review of the 5/2012 Physician Order Statement indicated there were Physician orders for the resident to have Prevalon boots on while in bed for pressure ulcers. There was an order initially written on 4/14/12 to cleanse the right medial ankle with normal saline, pat dry, apply Santyl, cover with Allevyn heel and Surgilast dressing daily and as needed. There was an order written on 4/28/12 to discontinue all treatments to the right ankle wound. Review of the 4/2012 Treatment Record indicated "D/C" was written in column for the right ankle treatment starting on 4/29/12. Review of the 5/2012 Treatment Record indicated there was a treatment to cleanse the area to the right ankle and right chest with normal saline, pat dry, and apply Santyl to the area and then cover with a Telfa dressing, change every 72 hours and as needed. The order for the above treatment was hand written on the Treatment record. The treatment was signed out as completed on 5/1/12, 5/4/12, 5/7/12, 5/10/12, 5/13/12, 5/16/12, 5/19/12, 5/22/12, 5/15/12, and 5/28/12.		Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees.**Monitoring:** The ADON, Director of Nursing (DON), or designee will check the green orders each morning during clinical review to ensure they have been initialed. The Unit Managers (UM), Assistant Director of Nursing (ADON) or designee will check the green phone orders to ensure they have been initialed. The UM, ADON, or designee will also check the nurses notes, MAR's, TAR's to ensure documentation was completed. The monitoring log will be checked daily, for 2 weeks, 3 times a week for 2 weeks, weekly for 4 weeks, then monthly for 3 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA monthly, to determine further educational needs.**Systems Changes:** Competed by 6/21/2012.	

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	When interviewed on 5/30/12 at 11:15 a.m., the ADON indicated the wound treatment to the right ankle area had been discontinued on 4/28/12. The ADON indicated the order for the right ankle wound treatment should not have been transcribed onto the 5/12 Treatment Record. 2. The record for Resident #E was reviewed on 5/29/12 at 11:00 a.m. The resident's diagnoses included, but were not limited, to urinary tract infection, high blood pressure, peripheral vascular disease and diabetes mellitus. The resident was sent to the hospital on 4/30/12 and returned to the facility on 5/2/12. Review of the 5/2/12 patient transfer order form indicated there were orders for the resident to receive Levaquin 500 milligrams once daily for 10 days to treat a urinary tract infection, Lipitor 80 milligrams every night, Captopril 12.5 milligrams twice a day, and Spironaldactone 25 milligrams once a day. Review of the 5/2012 Medication Record indicated the above four medications were not written on the Medication Record until 5/12/12. The Lipitor was first signed out as given on 5/12/12. The			

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	Levaquin, Captopril, and Spironaldactone were first signed out as given on 5/13/12. Review of the 5/2012 Medication Administration Record indicated the resident's blood pressure and pulse rates were recorded at 8:00 a.m. and 4:00 p.m. daily between 5/2/12 and 5/12/12. The resident's blood pressure and pulse reading remained within normal range for the resident. The highest blood pressure reading recorded was 170/81 on 5/5/12 with other readings averaging between 125/60 and 152/76. Review of the 5/2/12 hospital Discharge Summary report indicated the resident's urinalysis was positive for an urinary tract infection and the culture results were pending. The summary also indicated the resident was started Levaquin 500 milligrams once daily for ten days. Results of the hospital urinalysis and culture were not available in the resident's record at the time of review. The results of the culture and sensitivity were faxed to the facility on 5/29/12 at 2:26 p.m. per request.. The final culture and sensitivity report was completed on 5/4/2012. The results were positive for greater then 100,000 proteus mirabilis (an infection). The sensitivity report indicated proteus mirabilis was resistant to Levofloxacin			

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	(Levaquin). When interviewed on 5/29/12 at 3:40 p.m., the ADON indicated there were orders written on 5/2/12 for the above medications and the orders were not transcribed to the 5/2012 Medication Record. This federal tag relates to Complaint IN00108375. 3.1-50(a) 3.1-50(b)			